

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2024
NAME OF PROVIDER OR SUPPLIER  Advanced Rehab Center of Tustin		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 E. First Street Santa Ana, CA 92705	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</b></p> <p>Based on interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to implement their P&amp;P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility failed to report an allegation of resident-to-resident altercation to the law enforcement agency, CDPH L&amp;C Program, and Ombudsman office for three of six sampled residents (Residents 1, 2 and 3). This failure had the potential to put the residents at risk for further abuse.</p> <p>Findings:</p> <p>Review of the facility ' s P&amp;P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 9/2022 showed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations and thoroughly investigated by facility management. The administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing of the facility; the local/state ombudsman; adult protective services and law enforcement officials. Immediately is defined within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>1. Closed medical record review for Resident 1 was initiated on 8/9/24. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care hospital on 7/29/24, for further evaluation.</p> <p>Review of Resident 1 ' s MDS assessment dated [DATE], showed Resident 1 had a BIMS score of 15, indicating no cognitive impairment.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1 ' s progress note dated 7/29/24 at 0406 hours showed on 7/29/24 at 0100 hours, Resident 1 started arguing with Resident 2. Resident 1 went to the bathroom, closed the bathroom door, and continued to argue with Resident 2. Three staff members were able to separate the residents and one staff helped Resident 2 back into bed. Resident 1 continued to call Resident 2 names. Resident 3 overheard and started defending Resident 2. Resident 1 started calling Resident 3 names and both yelled obscenities at each other. As the staff member was removing Resident 3 from the room, Resident 1 pointed a table knife at Resident 3. The staff member asked Resident 1 to put it down. Resident 1 was asked if he wanted to move rooms and declined. Resident 1 stated he would call the police, but then decided not to as the incident was witnessed by three staff.</p> <p>2. Medical record review for Resident 2 was initiated on 8/13/24. Resident 2 was initially admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2 ' s MDS assessment dated [DATE], showed Resident 2 had a BIMS score of 10, indicating moderate cognitive impairment.</p> <p>3. Medical record review for Resident 3 was initiated on 8/13/24. Resident 3 was admitted to the facility on [DATE].</p> <p>Review of Resident 3 ' s History and Physical examination dated 7/21/24, showed Resident 3 did not have the capacity to understand and make decisions.</p> <p>On 8/9/24 at 1028 hours, an interview was conducted with Resident 3. Resident 3 stated Resident 1 pulled a knife on him. Resident 1 was using bad language to everyone. The nurses came in the room to intervene.</p> <p>On 8/9/24 at 1547 hours, an interview was conducted with the DON. The DON was asked about the incident occurring on 7/29/24 at 0100 hours, involving Residents 1, 2, and 3. The DON stated they were aware Resident 1 was yelling and screaming. The DON stated the incident was not reported by the staff and verified they were aware of the incident. The DON confirmed no reports were made to the CDPH L&amp;C Program, law enforcement agency, and ombudsman office regarding the incident.</p> <p>On 8/13/24 at 0840 hours, an interview was conducted with Resident 2. Resident 2 stated Resident 1 was yelling and using bad language. On the day of the incident, Resident 2 stated the volume of the television was up so as not to hear Resident 1 yelling and name calling. Resident 2 stated the incident happened 2 weeks ago, but it was only now Resident 2 was being interviewed about the incident.</p> <p>On 8/13/24 at 1344 hours, an interview was conducted with the DON. The DON stated Residents 1 and 2 were roommates and there was no altercation prior to the incident. The DON confirmed no reports were made to the CDPH L&amp;C Program, law enforcement agency, and ombudsman office regarding the incident.</p> <p>On 8/13/24 at 1405 hours, an interview was conducted with the Administrator. The Administrator stated he was notified of the incident on 8/9/24. The Administrator stated when Resident 1 pointed the knife on Resident 3, it should have been reported as abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24 at 1509 hours, a telephone interview was conducted with LVN 2. LVN 2 stated on 7/29/24 at about 0100 hours, LVN 2 overheard Residents 1 and 2 yelling at each other back and forth. Resident 1 pulled the emergency call light in the bathroom. Resident 1 could not get out of the bathroom. Resident 2, who was in a wheelchair, was sitting by the dresser blocking the bathroom door. Resident 1 was yelling using bad language towards Resident 2. Two CNAs were able to separate Residents 1 and 2. At around 0200 hours, Resident 3 went to Residents 1 and 2 's room. Resident 1 pointed a knife to both Resident 3 and LVN 2. The CNAs and LVN 2 were able to separate Residents 1 and 3. Resident 3 was escorted out of the room. LVN 2 requested the CNAs to provide one to one supervision to Residents 1 and 2. LVN 2 was asked if the incident was reported. LVN 2 stated it was documented in Resident 1 ' s progress notes. LVN 2 confirmed no report was completed. The Administrator, DON, and DSD were not made aware.</p>		